

§ 489.25

(F) An annual assessment of the community call plan by the participating hospitals.

[59 FR 32120, June 22, 1994, as amended at 62 FR 46037, Aug. 29, 1997; 65 FR 18548, Apr. 7, 2000; 65 FR 59748, Oct. 6, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59923, Nov. 30, 2001; 68 FR 53262, Sept. 9, 2003; 71 FR 48143, Aug. 18, 2006; 72 FR 47413, Aug. 22, 2007; 73 FR 48758, Aug. 19, 2008; 74 FR 44001, Aug. 27, 2009; 78 FR 50971, Aug. 19, 2013]

EFFECTIVE DATE NOTE: At 59 FR 32120, June 22, 1994, § 489.24 was added. Paragraphs (d) and (g) contain information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 489.25 Special requirements concerning CHAMPUS and CHAMPVA programs.

For inpatient services, a hospital that participates in the Medicare program must participate in any health plan contracted under 10 U.S.C. 1079 or 1086 (Civilian Health and Medical Program of the Uniformed Services) and under 38 U.S.C. 613 (Civilian Health and Medical Program of the Veterans Administration) and accept the CHAMPUS/CHAMPVA-determined allowable amount as payment in full, less applicable deductible, patient cost-share, and noncovered items. Hospitals must meet the requirements of 32 CFR part 199 concerning program benefits under the Department of Defense. This section applies to inpatient services furnished to beneficiaries admitted on or after January 1, 1987.

[59 FR 32123, June 22, 1994]

§ 489.26 Special requirements concerning veterans.

For inpatient services, a hospital that participates in the Medicare program must admit any veteran whose admission is authorized by the Department of Veterans Affairs under 38 U.S.C. 603 and must meet the requirements of 38 CFR part 17 concerning admissions practices and payment methodology and amounts. This section applies to services furnished to veterans admitted on and after July 1, 1987.

[59 FR 32123, June 22, 1994]

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§ 489.27 Beneficiary notice of discharge rights.

(a) A hospital that participates in the Medicare program must furnish each Medicare beneficiary or enrollee, (or an individual acting on his or her behalf), timely notice as required by section 1866(A)(1)(M) of the Act and in accordance with § 405.1205 and § 422.620. The hospital must be able to demonstrate compliance with this requirement.

(b) *Notification by hospitals and other providers.* Hospitals and other providers (as identified at 489.2(b)) that participate in the Medicare program must furnish each Medicare beneficiary, or representative, applicable CMS notices in advance of discharge or termination of Medicare services, including the notices required under § 405.1200, § 405.1202, § 405.1206, and § 422.624 of this chapter.

[71 FR 68724, Nov. 27, 2006]

§ 489.28 Special capitalization requirements for HHAs.

(a) *Basic rule.* An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term “initial reserve operating funds,” at the time of application submission and at all times during the enrollment process up to the expiration of the 3-month period following the conveyance of Medicare billing privileges to operate the HHA for the three-month period after Medicare billing privileges are conveyed by the Medicare contractor, exclusive of actual or projected accounts receivable from Medicare.

(b) *Standard.* Initial reserve operating funds are sufficient to meet the requirement of this section if the total amount of such funds is equal to or greater than the product of the actual average cost per visit of three or more similarly situated HHAs in their first year of operation (selected by CMS for comparative purposes) multiplied by the number of visits projected by the HHA for its first three months of operation—or 22.5 percent (one fourth of 90